## **Wyoming Application for Assistance**





This application may be used to apply for Temporary Assistance for Needy Families (TANF), known as Personal Opportunities with Employment Responsibilities (POWER), Child Care Assistance, Supplemental Nutrition Assistance Program (SNAP), EqualityCare (Medicaid), and Kid Care CHIP.

#### **HOW TO APPLY**

Please read all questions carefully and complete each section to the best of your knowledge. Please print your answers and sign the application using dark ink. You may have someone help you complete the application.

Take, fax, or mail the application to your local Department of Family Services (DFS) field service office once complete. An interview may be required to complete the application process. The address and phone number of your local DFS field service office can be found in the list located on http://dfsweb.state.wy.us/dfs/dfs-in-your-community.html or call 1-800-457-3659.

Some information on this application must be verified for each person applying.

#### RIGHTS AND RESPONSIBILITIES

By signing this application, you state that you understand the following:

#### **CITIZENSHIP/IMMIGRATION STATUS:**

My signature certifies that the citizenship/immigration status is correct for each person applying. If I am only applying for healthcare and/or Child Care benefits, I do not have to give information on citizenship or immigration status of family members who are not applying for benefits. I understand that my records will be kept confidential and will only be released for purposes authorized by federal and state law. Information I provide on this application may be shared with the U.S. Citizenship and Immigration Services (USCIS), formerly known as Immigration and Naturalization Services (INS), for POWER and SNAP applicants.

### **AUTHORITY TO REQUIRE SOCIAL SECURITY NUMBER:**

Social Security Numbers (SSNs) are required only for individuals who will actually receive SNAP, POWER, or EqualityCare benefits. SSNs are not required to receive Child Care. SSNs will be used in the administration of public assistance programs to check the identity of household members to prevent duplicate participation. SSNs will also be used in program reviews and/or audits to make sure your household is eligible for these programs. SSNs provided on this application may be shared with the USCIS for POWER and SNAP applicants. If you do not have an SSN for yourself or a household member, DFS can help you apply for one. Privacy Act of 1974; Title VI of the Civil Rights Act of 1964.

#### **CIVIL RIGHTS:**

In accordance with federal law, U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policies, DFS is prohibited from discriminating on the basis of race, color, sex, age, disability, religion, national origin, or political beliefs. To file a complaint of discrimination, contact DFS and/or USDA Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C., 20250-9410, (202) 720-5964; or HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, S.W., Washington, D.C., 20201, 1-800-368-1019 toll free or 1-800-537-7697 (TTY); or HHS Regional Manager, Office of Civil Rights, 1961 Stout Street, Room 1426, Denver, CO 80294, 1-800-368-1019 toll free or 303-844-3439 (TTY).

#### **COMPUTER MATCHES:**

The information you report will be checked by computer using SSNs. We will be comparing what you tell us with information on record with agencies such as the Department of Employment, IRS, Social Security Administration, Vital Statistics, Workers' Compensation, Department of Transportation, Child Support Enforcement, and the Department of Revenue and Taxation. All persons in your home applying for benefits will be included in the computer matches. Outside sources and/or your household members will be asked to verify other information. The information received may affect your eligibility and benefits. EqualityCare: Social Security Act § 1137, POWER: P.L. 104-193, as amended, W.S. 42-2-102, 42-2-103, 42-2-104, 42-2-106, ARW POWER, Chapter 1; SNAP: 7 CFR 272.8 and .11, 7 CFR 273.2, 7 CFR 273.16 and 7 CFR 273.18.

### **RELEASE OF CONFIDENTIAL INFORMATION:**

Subject to certain limited exceptions, the information you provide is kept confidential. Information may be disclosed to other federal and state agencies for official examination and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. For the purpose of administration of the Wyoming Medical Assistance and Services Act, DFS, or the Wyoming Department of Health (WDH) may disclose information limited to a recipient's name, SSN, amount of payment, charge for services, date of services and services rendered related to EqualityCare payments made under this Act ("assistance payment information"). Any state agency, insurer, group health plan, health maintenance organization, or similar entity shall, upon request from WDH, disclose the same limited information. A violation of these confidentiality requirements is a "misdemeanor punishable by imprisonment for not more than six months, a fine of not more than seven hundred fifty dollars (\$750), or both." W.S. 42-4-112(c)

DFS or WDH may give the information you provide, without your consent, in the following circumstances:

- 1) To federal, state or local authorities responsible for administering or enforcing the regulations of the program for which you apply or receive benefits. These authorities may begin an investigation or bring civil or criminal action on the basis of the information received regarding your case.
- 2) To a court, judge, or other administrative legal body, but only when the information is required in a civil or criminal proceeding.
- 3) Eligibility information relating to a child may be released to the non-custodial parent. If you have a court or restraining order that prohibits the release of this information, please include a copy of the order with your application. W.S. 20-2-201(e)

#### **ADMINISTRATIVE HEARING:**

If you feel our decision to deny, change, or reduce your benefits is incorrect, you may request a conference with WDH or your local DFS field service office. If you still do not agree after that conference, you may request an administrative hearing from the DFS field service office. A SNAP hearing request may be requested orally or in writing and an informal conference is optional and in no way will delay or replace the fair hearing process. Except for POWER performance payments and Child Care, if you request the administrative hearing within 10 days of being notified, the change or

reduction will not take place until the administrative hearing has been held and a decision has been made. If you do not request an administrative hearing on Child Care or POWER, or EqualityCare actions within 30 days, or 90 days for SNAP, your request will be denied. The local DFS field service office will help you in arranging for a local conference or in making a request for an administrative hearing with the State. You may be represented by a lawyer, relative, friend, other person, or you may represent yourself. If you hire a lawyer, you must pay all the legal charges.

If you want to discuss our decision or ask any questions about how an administrative hearing works, contact us. You may also call the local Legal Services Office to find out if free legal advice is available. 7 CFR 273.12; 7 CFR 273.15, 42 CFR 431 Subpart E; P.L. 104-193, as amended, W.S. 42-2-102, 42-2-103, 42-2-104, 42-2-106, 42-2-109, 42-2-112, 42-2-202, 42-2-106, ARW POWER, Chapter 1; ARW Child Care, Purchase of Service, Chapter 1

#### RELEASE OF MEDICAL RECORDS:

I understand that WDH, Blue Cross Blue Shield of Wyoming, and/or Delta Dental of Wyoming must be able to obtain medical records from providers if necessary. My signature authorizes my family's medical provider to release any medical records to WDH, Blue Cross Blue Shield of Wyoming, and/or Delta Dental of Wyoming.

#### **ESTATE RECOVERY:**

WDH will pursue recovery of medical care costs paid by the EqualityCare program from the estate of an EqualityCare recipient who was age 55 years or older when they received medical assistance or who was an inpatient in a medical institution when they received medical assistance.

#### **DISQUALIFICATION PENALTIES:**

Any adult household member who breaks these rules/regulations can be barred from receiving SNAP benefits as follows:

- You could be subject to criminal prosecution for knowingly giving false information and could lose your benefits for twelve (12) months on the first violation and twenty-four (24) months on the second violation. You may be permanently disqualified for the third violation and still be subject to prosecution under state and federal laws.
   This also applies to POWER and Child Care.
- Recipients found guilty of purchasing controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) shall be disqualified for two (2) years for a first offense and permanently for a second offense
- Recipients found guilty of purchasing firearms, ammunition or explosives with SNAP benefits shall be disqualified permanently for the first offense.
- Recipients found guilty of having trafficked benefits for an aggregate amount of \$500 or more shall be disqualified permanently from the SNAP program upon the first occasion of such violation.
- Recipients who make a fraudulent statement of misrepresentation to their identity or their place of residence in order to receive additional SNAP benefits simultaneously shall be disqualified for a period of ten (10) years.

#### **WARNING:**

Federal, state, or local assistance workers may check everything you tell us on the application. Refusal to cooperate with any authorized federal or state agency may result in denial or loss of benefits. Do not lie or hide information to get benefits that your household should not get.

Federal SNAP regulations provide for a fine of up to \$250,000 and/or imprisonment from one (1) year up to twenty (20) years for any person who attempts to receive or receives SNAP benefits to which the person(s) is not entitled. You may also be barred from the SNAP program for an additional eighteen (18) months if court ordered. He or she may also be subject to prosecution under other applicable federal and state laws.

#### **REPORTING CHANGES:**

I understand that I am responsible for reporting changes to the information I have provided on this application so that I can receive the benefits for which I am eligible.

You must report and verify any change immediately upon finding out about it for POWER. You must report and verify any change within ten (10) days for Child Care, EqualityCare, and SNAP.

Following are some examples of changes you will need to tell us about for yourself and the people living with you:

- Earnings
- Other Income
- Resources/Assets (not needed for EqualityCare Family and Children's Programs, the Employed Individual with Disabilities program, and Kid Care CHIP)
- Student Status
- Living Arrangements/Address/Child Care
- Health Insurance

Do you expect any of this to change or has it already changed? If so, call, write or complete and turn in a Change Report form along with verification of the change (verification not needed for EqualityCare Family and Children's programs or Kid Care CHIP). DO NOT let your benefits go down or cause an overpayment just because you did not let us know about the change. 7 CFR 271.5, 7 CFR 273.12, ARW SNAP, Chapter 1; 42 CFR 435.916; P.L. 104-193, as amended, W.S. 42-2-102, 42-2-103, 42-2-104, 42-2-106, 42-2-109, 42-2-112, 42-2-202, 42-4-106, ARW POWER, Chapter 1; ARW Child Care, Purchase of Service, Chapter 1.

YOU ARE RESPONSIBLE FOR THE ACCURACY OF YOUR BENEFITS. IF YOU DO NOT KNOW IF YOU SHOULD REPORT A CHANGE, REPORT IT!

## **TELL US ABOUT YOU**

	he applicant in the ta	ADIC DCIOV	٧.		
Last name:	First name: Middl			Middle in	itial:
Social Security Number: (Not required	d for Child Care)	Date of	birth:		Sex: (M or F)
		/	/	(MM/DD/YYYY)	
Address where you live (street, city	, state, zip):				
Mailing address (if different): (stree	t, box#, city, state, z	ip):			
Home phone:	Cell/Message ph	one:		Work phone	9:
Email address:		Wh	at is you	ır preferred langu	age?
Place of birth (City/State or Country):	Last grad	de comp	leted:		
Do you currently live in Wyoming?	☐ Yes ☐ No If No.	estimate	d date o		/
Are you a US Citizen? ☐ Yes ☐ No	o If No, provide perr	nanent Re	esident A	Alien Registration	#:
Date o	of entry into the US:			/ (MN	1/DD/YYYY)
Is your ethnicity Hispanic or Latino?	Yes □ No ( <b>Opt</b>	ional)			
Race:   American Indian/Alaska N	ative □ Asian □ N	ative Haw	/aiian/Pa	acific Island 🛭 Bl	ack 🗆 White
	(0	ptional)			
☐ Other, specify:		,			
□ Other, specify:  NOTE: For Child Care Assistance, parent applying.			ired for	a child receiving (	Child Care, not for the
<b>NOTE:</b> For Child Care Assistance, parent applying.	, citizenship status is		ired for	a child receiving (	Child Care, not for the
NOTE: For Child Care Assistance, parent applying.  SIGN AND DATE APPLICATION HERE	, citizenship status is	only requ			
<b>NOTE:</b> For Child Care Assistance, parent applying.	, citizenship status is	only requ			Child Care, not for the

**NOTE:** SNAP applicants have the right to file an incomplete application as long as it contains the name, address, and signature of a responsible household member or an authorized representative.

Check the programs you wish to apply for. Your income and assets/resources may be considered when applying for these programs.
☐ <b>Child Care</b> – Assistance in paying for childcare while parent(s) works, attends employment training or school.
☐ Child Support Enforcement (CSE) Services — A referral for assistance in locating non-custodial parent(s), establishing paternity, enforcing court orders and collecting child support. CSE may help children get financial and medical coverage from parents who do not live in the home and who are or can be court ordered to provide financial or medical coverage. There may be a small fee for this service.
<u>Medical Coverage</u> – If a child is eligible for EqualityCare (Medicaid) and a parent does not live in the home, we may make a referral to CSE. We will not make a referral for children who are eligible for Kid Care CHIP. If you have a child eligible for Kid Care CHIP and you would like assistance with CSE, please contact them at 1-800-742-3096.
<u>POWER/TANF</u> – If you receive POWER and one parent is not living in the home, your family will automatically be referred to CSE. You must cooperate with CSE in establishing paternity and in establishing and enforcing child support.
If you are interested in receiving EqualityCare or POWER coverage for yourself and/or your children and you do not want assistance from CSE because your cooperation might not be in the best interest of your child (example: domestic violence situation), you may claim "good cause." If you do want assistance, you must submit a good cause claim with evidence so we can decide if there is "good cause."
Are you interested in claiming "good cause" for not cooperating with CSE? $\square$ Yes $\square$ No
Claiming "good cause" does not affect your child's eligibility for EqualityCare and/or POWER.
Failure to cooperate with CSE does not affect your child's eligibility for EqualityCare or Kid Care CHIP. However, if you choose not to cooperate with CSE efforts and you have not claimed "good cause" or your claim of "good cause" has been denied, you will not be eligible for EqualityCare coverage or POWER benefits. However, your children will continue to be eligible for EqualityCare or Kid Care CHIP, provided they meet all other program requirements.
☐ <b>EqualityCare</b> — A joint federal and state government program that pays for medical care for some low-income and medically needy individuals and families.
The EqualityCare Family and Children's programs help pay for healthcare services for children, pregnant women, and families with children who qualify based on citizenship, residency, family income, and sometimes resources and healthcare needs.
The EqualityCare Aged, Blind, or Disabled (ABD) programs help pay for healthcare services for individuals who are institutionalized, need home and community based services, or are employed with disabilities and who qualify based on citizenship, residency, family income, and sometimes resources and healthcare needs. ABD programs can also assist individuals in paying for their Medicare Premiums if qualifications are met.
☐ <b>Kid Care CHIP</b> – A Children's Health Insurance Program that provides health insurance to eligible uninsured children under the age of 19. Your application will be forwarded to Kid Care CHIP if you are found ineligible for EqualityCare Family and Children's programs due to excess income.

☐ <b>Personal Opportunities With Employment Responsibilities (POWER)</b> – Cash assistance for families who cooperate vith seeking child support and work. POWER is limited to 60 months.							
☐ <b>POWER–SASFA</b> – Cash assistance for single parents who are attending covocational training program.	ollege for their first degree or first						
☐ <b>Supplemental Nutrition Assistance Program (SNAP)</b> — Benefits to help be the date of application. The filing date is different if the household is in an at the same time. In this case the filing date is the date of release from the	institution and applying for SNAP and SSI						
□ Other, specify:							
For Office Use Only:							
Appointment Date: Worker Name:							
Appointment Time:							
MEDICAL SUPPORT ASSIGNMENT							
<ul> <li>I hereby assign any rights to back, current or future support/alimony to the eligibility for POWER. By signing this application, I understand any amount myself or on behalf of children named on this application must be turned in I understand as a condition of eligibility, I must assign medical support as form.</li> <li>If my medical bills are paid by EqualityCare or Kid Care CHIP and I also go another source, or the medical bills are paid by another insurance compute to WDH; and</li> <li>WDH may collect from any liable third party, insurance company, or from judgment for all medical bills; and</li> <li>I must give the money to WDH for 100% of the medical bills paid from a receiving any of the manager or other bandits from the cettlement or incompany.</li> </ul>	of support/alimony owed or paid for into DFS.  Ollows:  get money for the same medical bills from pany or third party, I must give the money om the proceeds of any court settlement or any settlement or judgment prior to my						
receiving any of the money or other benefits from the settlement or jud I HAVE READ AND FULLY UNDERSTAND MY RESPONSIBILITIES ABOVE, AND RECEIVE POWER, EQUALITYCARE, OR KID CARE CHIP.							
Signature of Applicant/Recipient/Authorized Rep/Caretaker Relative	Date						
Signature of Minor Parent	Date						

# **DECLARATION**

	Please complete the declaration	section if you are	applying for SNAP,	Child Care or POWER.
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<ul> <li>Are you or any member of your househoused, going to jail for a felony crime of Yes □ No</li> <li>Is anyone for whom you are requesting of further domestic violence? (Not need Have you or any member of your house September 22, 1996? □ Yes □ No</li> <li>Have you or any member of your house 1996? □ Yes □ No</li> </ul>	or attempted felony assistance fleeing fo ded for SNAP)	crime, or violating a cond r personal safety, a victimes \( \subseteq \text{No} \) of buying or selling SNAP of trading SNAP benefits	lition of parole or probation?  of domestic violence or at risk benefits over \$500 after for drugs after September 22,
<ul> <li>Have you or any member of your house</li> <li>State after September 22, 1996? ☐ Ye.</li> </ul>		of fraudulently receiving	duplicate SNAP benefits in any
<ul> <li>Has anyone for whom you are requestir state? ☐ Yes ☐ No</li> </ul>		d benefits of any kind in \	Wyoming or from another
Benefits last received: Month	Year	City	State
<ul> <li>Is anyone for whom you are requesting</li> <li>Is any household member applying for S</li> <li>Is any household member applying for S</li> <li>Are you or is any household member no disqualified, from the SNAP for providin a case worker that affected SNAP eligibited.</li> <li>Have you or any member of your house explosives after September 22, 1996?</li> </ul>	SNAP or POWER bendand bendand benefits disable ow disqualified, or having incorrect informatility and benefits? Ethold been convicted	efits on strike?	l No nold member ever been iling to provide information to
I certify under penalty of perjury all answer members applying for benefits, are true a statements given on this form. I understal lower amount of benefits and payment or connection with this application for benefit determine if such information is factual a subject to criminal prosecution for knowing application will be kept on file for 30 days being denied.	and correct and agree and answers I provide r no benefit or paym fits will be subject to nd that if any inform ngly providing incorr	e to provide information in the here may result in change ent. I understand the info verification by federal, station is incorrect benefits ect information. For SNA	f it is needed to verify any ges in my benefits including a primation I provide in tate, and local officials to s may be denied, and I may be P benefits, I understand my
Signature:		Date:	

HELP US DECID	DE IF YO	OU CAN	RECEIVE SNAF	WITHIN SEVE	N DAYS			
If you are appl	ying fo	r SNAP,	completing thi	s section may	help you recei	ve benefits with	in seven days:	
2. Are you a r	nigrant	t or seas	onal farm wor	ker? □ Yes □	□No			
3. How much	total e	arned i	ncome will you	r household re	ceive this mo	nth before taxes	(gross)? \$	
4. How much	total u	inearne	d income or ot	her money will	your househ	old receive this r	nonth? \$	·
5. Total amou	unt of I	iquid res	sources availab	ole (cash on ha	nd, checking a	ınd savings acco	unts): \$	
6. How much	is you	r housel	nold's monthly	rent, lot rent a	and/or house	payment? \$		(total)
7. Check all th	ne utili	ties you	r household is	responsible for	r:			
☐ Heating	□ Coo	ling 🗆	Electricity 🗆	Telephone $\square$	Water □ Se	wer 🛮 Garbage		
Do househ	old me	mbers r	eceive heating	assistance (LIE	EAP)? □ Yes	□ No		
8. Do you hav	ve a Wy	oming	Electronic Bene	efit Transfer (E	BT) card for SI	NAP? □ Yes □	No	
			Age	ncy Use Only –	- Expedited Fo	rmula		
Step 1		Step 2				SUA – Any of th following:	e UO – Tollowi	wo of the
		Δ Βει	nt/Mortgage \$			Heating		Water
Monthly Incombelow \$150/M			propriate Utilit			<ul> <li>Cooling</li> </ul>		Sewer
and liquid	ionth	C. Mc	onthly Gross Inc	come + Liquid		• LIEAP	•	Garbage
resources are		Res	ources \$				•	Electric Telephone
below \$100, th	nen						•	relephone
expedite		If A + B	is greater tha	n C then exped	lite			
Was the screen	ning fo	r expedi	ted service cor	mpleted? 🗆 Ye	es 🗆 No	Worker Initials:		_
Is the househo	ld eligi	ble for e	expedited servi	ce? □ Yes □	No	Case Number: _		
Was the Identi	ty of th	ne appli	cant verified? [	☐ Yes ☐ No		Date Received:		<del></del>
HELP US DECIDE IF YOU CAN RECEIVE CHILD CARE WHILE WE PROCESS YOUR APPLICATION								
9 Are all of th	he nare	ents in t	he household v	vorking or atte	ending school/	training? $\Box$ Ves	Пио	
<ul><li>9. Are all of the parents in the household working or attending school/training? ☐ Yes ☐ No</li><li>10. What days of the week and times does each parent work or go to school/training?</li></ul>								
10. What days							Saturday	
You				-			-	
Other Parent								
11. How much total earned income will your household receive this month before taxes (gross)? \$								
12. How much total unearned income or other money will your household receive this month? \$								
13. Who is you	13. Who is your childcare provider?							
14. Is your pro	vider li	censedî	P □ Yes □ No	)				
DEC 100								

DFS 100 (03/11)

## TELL US ABOUT THE PEOPLE IN YOUR HOME

15. Complete the information below for all persons living with you:

Household Members	Place of Birth	Relation To You	Relation to Spouse/ Significant	Social Security #	Date of Birth	Sex (M	Last Grade Com-	Do They Currently Live in	U.S. Citizen	Hispanic or Latino	Race (Use
(Enter Legal Name) Last, First, Middle Initial  ✓ if applying for Kid Care CHIP	City/State or Country		Other	(Not required for Child Care)		or F)	pleted	Wyoming? (Yes or No) If No, estimated date of residency	(Yes or No) If No, provide Alien # & date of entry	(Yes or No) Optional	codes below) Optional
		☐ Spouse ☐ Significant Other									
		☐ Child☐ Step-Child☐ ☐	☐ Child☐ Step-Child☐ ☐								
		☐ Child☐ Step-Child☐ ☐	☐ Child ☐ Step-Child ☐								
		☐ Child ☐ Step-Child ☐	☐ Child☐ Step-Child☐ ☐								
		☐ Child ☐ Step-Child ☐	☐ Child☐ Step-Child☐ ☐								
		☐ Child ☐ Step-Child ☐	☐ Child ☐ Step-Child ☐								
AI – American India O – Other, specify: _					fic Island	BL – Bl	ack WH	– White			

**NOTE:** Additional household members can be listed on page 16 of the application.

DFS 100

16. For a	6. For any child(ren) under the age of 18, listed in #15, is there a parent who is not living with you? ☐ Yes ☐ No							
If Ye	If Yes, name of child(ren),							
Nam	Name of parent(s) not living with you:,							
Are	you the custodial parent? ☐ Yes ☐ No							
-	7. If applying for EqualityCare or Kid Care CHIP, for any child with a custodial parent listed in #15, does the child(ren) live with the parent at least 50% of the time? $\square$ Yes $\square$ No							
If Ye	s, name of child(ren):		<del></del>					
	plying for POWER, for any child with a custodial pa ast 51% of the time?	aren	t listed in #15, does the child(ren) live with the parent					
If Ye	s, name of child:		<del></del>					
TELL US	ABOUT YOUR HOUSEHOLD'S ASSETS/RESOURCES	5						
or Kid Ca <b>Assets/I</b>	ou do not need to complete this section if applying are CHIP.  Resources — Vehicle information should be entered to the box by the assets/resources owned, jointly on the section if applying the content of the content	d in t						
	Burial Space Items (Casket, Vault, Marker, etc.)		Life Insurance Individual Indian Monies Accounts Life Estate/Life Lease Mineral Rights (Oil, Gas, Gravel, Coal, etc.) Notes or Contract for Deed Prepaid Funeral Plans Real Property (Land, House, Buildings, etc.) Retirement Funds (IRA/Keogh/401K) Safety Deposit Box Savings Bonds Savings/Credit Union Accounts Stocks/Bonds/Mutual Funds Trusts Pooled Trusts Special Needs Trusts					
	Other, specify:		<del>-</del>					

For all items checked in #19, fill in the boxes below:

Type of Asset/Resource	Location/Description	Total Value	Amount	Owners
			Owed	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
	·	\$	\$	
		\$	\$	

ι	ransfer, trade, or give away any items of value?				•
-		, desc	ription of	item	
(	date item sold/transferred/traded/given away	/	/	(MM/DD/YYYY),	
١	value \$, amount received \$ _			, name of person the item was	
9	sold/transferred/traded/given away to:				
Vehi	icles				

List vehicles (cars, trucks, motor homes, snowmobiles, motorcycles, 3 wheelers/4 wheelers, boats or other watercrafts, campers, trailers, etc.) owned, jointly owned, or being purchased for all household members, even if the vehicle is not running or not in your possession. Include vehicles licensed in Wyoming or another state, as well as tribal motor vehicles.

Make/Model	Year	Value (Optional)	Amount Owed	Licensed	Owners
		\$	\$	☐ Yes ☐ No	
		\$	\$	☐ Yes ☐ No	
		\$	\$	☐ Yes ☐ No	
		\$	\$	☐ Yes ☐ No	
		\$	\$	☐ Yes ☐ No	
		\$	\$	☐ Yes ☐ No	

If you indicated Yes above for a licensed vehicle, what state(s) is the vehicle(s) licensed in?	

## TELL US ABOUT THE INCOME/MONEY YOUR HOUSEHOLD RECEIVES

**Note:** Required for all programs.

## **Unearned Income or Other Money Received**

following is a list of different kinds of unearned in money received by household members.	com	ne. Check the box for each unearned income o
Bureau of Indian Affairs/Tribal General Asst. Bingo/Gambling Winnings Charity Income Child Support Monies Contract Sale Educational Income (Financial Aid) Income from Tribes Income from Roomer/Boarder Indian Tribal Funds, Per Capita Insurance/Lawsuit Settlement Money from Friends, Relatives, or Others Oil/Mineral Rights/Royalties Pension/Retirement Benefits Railroad Retirement Benefits		Rental Income Reverse Mortgage Social Security Benefits - Survivor Social Security Benefits - Disability Social Security Benefits - Retirement Social Security Benefits - Other Spousal Support (Alimony) Stocks/Bonds/Interest/Dividend Income Supplemental Security Income (SSI) TANF/POWER Unemployment Benefits Veterans'/Military Benefits Workers' Compensation
Other, specify:		

For all items checked above, fill in the boxes below:

Type of Unearned Income or Other Money Received	Household Member	How Often Received	Amount Last Month	Amount This Month

# **Employment**

22. Are any ho	ousehold me	embers emp	oloyed? 🗆	] Yes □ No	If Yes, list i	informatior	n about pay	from em	ploymen	it, such
as wages,	commission	s, bonuses,	and ince	ntives for all	household	members ir	ncluding chi	ildren:		
Reminder	: Gross Pav i	s vour pay	before ta	xes and ded	uctions are t	aken out, N	IOT vour ta	ke home	pav.	
Household Member	Employer	Hours Worked Per Week	Hourly Pay	Last Month's Pay	This Month's Pay	Amount of Tips	Amount of Tips  This	Date of Next Check	How Often Paid	Day of Week Paid
				Before Taxes & Deductions (Gross)	Before Taxes & Deductions (Gross)	Month	Month		Use C Bel	Codes
How Often Pa	id Codos:									
M – Monthly		a Month	W – Wee	ekly EX – Ev	very 2 Week	s Other, s	pecify:			
Day of Week I		14/ 14/-	d d	TU Thomas	.da E E:	alani C Ci	. k da CI	I. C day		
M – Monday	ı – ruesaa	y w – we	anesaay	IH – Inurs	day F – Fri	day 5 – Sa	aturday Si	J - Sunda	У	
23. Has any ho within the			o If Yes, l	ist the hous	nuses, tips, on the second member of the second member of the second members of the seco	oer (s):				
amount: \$	; 			, type (	of income: _					
24. Are you or settlemen	-		-	-	/ou received ] Yes □ No		e payment (	(for exam	ple a	
If Yes, who	received th	ne payment	:?				, date ¡	oayment i	eceived	:
	//_	(1	MM/DD/YY	YY), amount:	\$	, v	vho was the	e paymen	t receive	d
from?										
Self-Employm										
25. Are any ho	ousehold me	embers self	-employe	d? □ Yes [	□ No If Yes	, list the ho	usehold me	ember(s):		
				, name(s) a	and type of I	ousiness:				
date busi	date business started:/(MM/DD/YYYY)									
572400										

DFS 100 (03/11)

26. Is the self-employed	household member(s) paid a	regular wag	e or salary? 🏻 Ye	s 🗆 No		
If Yes, last month's in		, this month's income before				
taxes (Gross) \$						
	out of pocket business expens	ses? □ Yes	□No			
	·					
TELL US ABOUT STUDEN	TS IN YOUR HOME					
28. List each Household	Member who is a student or e	enrolled in s	chool:			
Student Name	Name of School	Student Age	PT – Part Time FT – Full Time	Credit Hours Enrolled	Do You Have a Degree or Certificate? Y/N	
PLEASE COMPLETE THE	FOLLOWING SECTION IF YOU	ARF APPLY	ING FOR SNAP			
	nember quit or reduced hours  member receive Food Distribi		·		<u>.</u>	
,	s, who?:	J		,		
expenses. For calcul canceled checks, etc do not wish to claim expenses being allow expenses have been same during your ce  Dependent Care — A child to and from child have paid out of poc — To see — To atte	•	dicate whet ill NOT be el the expense ication of the SNAP bene the SNAP face provider to byment.	her you choose the igible for a deduct e. Your application he actual expense of the fits, the amount of the endent care and remily income when to claim a dependent care and remily income when the endent care and remarks of the endent care and remar	e deduction and ion if you have in will be process by the requested the deduction (asonable costs of the care is need the care deduction).	provide the bills, indicated that you sed without the date. Once you s) will remain the of transporting a ded. You must	
☐ We have this expe	ense and wish to claim the decense and do not wish to claim to claim. Number of miles:	the deducti	on.			
DFS 100						

DFS 100 (03/11)

☐ Does anyone	e outside of your h	ousehold help pay	y this expense? ☐ Yes ☐ No	If yes, who
		and how muc	h do they pay? \$	
· · · · · · · · · · · · · · · · · · ·	rable shelter costs helter, and propert		rent, first and second mortgage ance.	es, other expenses leading to
□Rent	□Lot Rent	$\square$ Mortgage	☐Second Mortgage	□Other
☐ We have this☐ We have this	s expense and do r	ot wish to claim t	uction. Amount: \$he deduction. y this expense?  \[ \sqrt{Yes}  \text{No} \]	
		and how muc	h do they pay? \$	
<u>Utility</u> – Allowa telephone expe		clude: heating or c	cooling expenses, lights, cookir	ng, fuel, water, etc., and basic
□Cooking	□Fuel	□Water	☐Telephone/Cell Phone	□Other
☐ We receive I☐ Does anyone	e outside of your h	ousehold help pay	he deduction.  y this expense? □ Yes □ No  h do they pay? \$	
	Payments – Legally , such as rent and/	_		nclude arrearages or payments
☐ We have this☐ We have this	s expense and do re outside of your h	ot wish to claim t ousehold help pay	y this expense? ☐ Yes ☐ No	
		and how muc	h do they pay? \$	
another govern \$35 which have [ [ [ ]	nment agency for penot been reimburent and den Medical and den Medication, equivaling Medical insurance Medical related to Reasonable trans	ermanent disabilities, including (chapter) tall expenses, including the content of the	ty under the Social Security Aceck any that you pay): uding psychotherapy and rehalatendant care hearing aids, prosthetics, eyestified health professional	glasses, when prescribed by a vision, and dental care

$\square$ We do not have this expense.	
<ul><li>☐ We have this expense and wish to claim the deduction. Who</li><li>☐ We have this expense and do not wish to claim the deduction.</li></ul>	, Monthly Amount \$
☐ Does anyone outside of your household help pay this expense? ☐ Yes	☐ No If yes, who:
and how much do they pay? \$	•
PLEASE COMPLETE THE FOLLOWING SECTION IF YOU ARE APPLYING FOR PO	WER
32. List all household members that are married:	
33. Has any household member quit or reduced hours/wages within the last 6	0 days? □ Yes □ No
If Yes, who:	
34. Does any household member pay legally obligated child support? ☐ Yes 【	
If Yes, who:,	monthly amount \$
35. Is shelter provided to you free of charge? ☐ Yes ☐ No	
36. Do you live in subsidized housing? ☐ Yes ☐ No	
PLEASE COMPLETE THE FOLLOWING SECTION IF YOU ARE APPLYING FOR EQU	UALITYCARE OR KID CARE CHIP
<ul><li>37. Are you or anyone in the household, listed in #15 (page 9), pregnant? ☐ You following questions:</li><li>a. Name of person(s) who is pregnant:</li></ul>	
<ul> <li>b. Has a doctor or health professional informed the pregnant woman</li> <li>c. Due Date:/(MM/DD/YYYY)</li> <li>d. How many babies are due?</li> </ul>	of her due date? ☐ Yes ☐ No
e. Is this her first pregnancy? ☐ Yes ☐ No	
<ul><li>f. Name of father:</li><li>g. Does the baby's father live with you? ☐ Yes ☐ No</li></ul>	
<ul> <li>h. If the pregnant woman is under the age of 18, tell us who lives with parent(s), □ Father of unborn baby, □ On her own, □ Other</li> </ul>	n her: Check all that apply: ☐ Her
i. Do you want to be referred to a Public Health Nurse for prenatal ed	ducation? 🗆 Yes 🗆 No
List all household members that are married:	
38. Does anyone in your household have a Companion or Care Contract in place	ce? □ Yes □ No
39. Does a child in your household, under the age of 18, have a diagnosed med	dical condition? ☐ Yes ☐ No
If Yes, list name of child(ren) and diagnosed medical condition(s):	

Household Member	Type of Ins	urance	Name of Insu Company	irance	Policy Number	Group Number
Has anyone in the hous SO days? ☐ Yes ☐ No		•		_		e that ended in th
Household Member		Date Insu	rance Ended	Reason	Insurance Ended	
Yes No If Yes, ple	ease list belov	W:	D		.:	1
Name			Da	te of Serv	Исе	
f Yes, please list the gro	oss amount (i	ncome befo				ily income for the
f Yes, please list the gro nonths: <b>Gross Amount</b>	oss amount (i	ncome befo		uctions)		ily income for the
f Yes, please list the gro months: <b>Gross Amount</b> Last Month: \$	oss amount (i	ncome befo	ore taxes or ded	uctions)		ily income for the
f Yes, please list the gro months: <b>Gross Amount</b> Last Month: \$ 2 Months Ago: \$			ore taxes or ded	uctions) De	and type(s) of fami	
f Yes, please list the gro months: <b>Gross Amount</b> Last Month: \$			ore taxes or ded	uctions) De	and type(s) of fami	
f Yes, please list the gromonths:  Gross Amount  Last Month: \$ 2 Months Ago: \$ 3 Months Ago: \$	sehold serve	d in the Arr	Typened Forces?	uctions)  De  Yes	and type(s) of fami	
f Yes, please list the gromonths:  Gross Amount  Last Month: \$ 2 Months Ago: \$ 3 Months Ago: \$	sehold served	d in the Arn	Typened Forces?	uctions)  De  Yes	and type(s) of fami	
f Yes, please list the gromonths:  Gross Amount  Last Month: \$ 2 Months Ago: \$ 3 Months Ago: \$ Has anyone in your households.	isehold served old member(s	d in the Arr s): dent of a Ve	re taxes or ded  Type  ned Forces?	uctions)  De  Yes	and type(s) of fami	

#### **AUTHORIZATION TO FURNISH INFORMATION**

For purposes of determining eligibility, I allow any person having information about me or other household members to give any requested information, including confidential information, to any authorized agent of the State of Wyoming or the federal government. I also agree to provide information necessary to verify any statement given on this application, to update information promptly, and to cooperate fully with all officials of the State of Wyoming in investigations based upon this application or the information it contains. The information on this application may be referred to federal and state agencies, as well as private claims collection agencies, for claims collection action against persons fraudulently participating in or giving false information to be eligible for these programs. A copy of this authorization is as valid as the original.

I certify I have read this form, or it has been read to me, and the information given is true and correct. I understand the information given is voluntary and lack of required information could affect eligibility for certain programs. I agree to provide information if it is needed to verify any statements given on this form. I authorize DFS to make inquiry of persons, companies, financial institutions or other agencies to obtain additional information or to verify my statements. I will report and verify any change immediately upon finding out about it for POWER or within ten (10) days for Child Care, EqualityCare (Aged, Blind or Disabled programs) and SNAP. I understand the information I provide on this form may result in changes in my benefits, including a lower amount of benefits or no benefits. I declare the identity of minors named on this form to be true and correct.

SIGN AND DATE THE APPLICATION HERE	
Signature of Applicant:	Date:
Signature (Spouse, Guardian or Other Adult):	Date:
Signature (Spouse, Guardian or Other Adult):	Date:
Signature of Authorized Representative:	Date:
Signature of Authorized Representative:	Date:
Worker Signature:	Date:

Please use this space if you need additional room to answer questions from the application. If you use all of this space please attach a separate page. Please be sure to write the question number next to the response. Please use this space for additional comments or if you have any additional information you would like to include.					